"MATURE" MINORS & THE MEDICAL LAW; SAFETY FIRST?

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[2004] COLR 6

Introduction

Irish law is notable for its lack of jurisprudence on adolescent medical decision-making. It is thus difficult to discern how our judiciary would approach the issue. The PKU [2] case broadly demonstrated the competing concerns at play where any decision must be taken about matters affecting a child's health. The Chief Justice's dissenting judgment there prized protecting the welfare of the vulnerable above all else. The majority ruling emphasised the conviction that state interference with family decisions of this kind should be the exception rather than the rule. The English approach to the law of adolescent consent and capacity is therefore a useful subject for study. It is imbued with the same tensions, which have reared their heads on this side of the Irish Sea; between institutional attachment to benevolent paternalism and the liberal talisman of individual autonomy. Crucially, it demonstrates what may happen when we raise the stakes; when the decision is made not by the adult parent but by the "vulnerable" child himself. It is my submission that English jurisprudence has gone the route of excessive caution. It is heavy with a sense that it is unwise to trust teenagers with the serious business of making medical decisions for themselves. And so, there is a status-inspired bias woven into this area of law: one that leans firmly towards more "reliable" decision-maker. Interestingly,

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[2] *North Western Health Board v W.(H.)* [2001] 3 IR 635

the case law on this matter couches its paternalism in the mechanisms of the functional approach to capacity. This tactic breeds a jurisprudence, which is dangerous of itself. Despite its surface attempt to give teenagers the best of both worlds, it is incoherent, unsound and unjustifiably discriminatory.

Consent to Medical Treatment: Dangerous Ground ?

The law of consent is the focus of all treatment decisions from the controversial to the mundane. To treat another without his consent[3] amounts to the criminal offence of battery. We may therefore understand the consent requirement as a crucial safeguard of the patient's bodily integrity. The concept is however, as much a sword as a shield. The patient may do more than blithely assent to his doctor's preferred course of action. He is the captain of his own fate; empowered to take a full part in the therapeutic process and to make autonomous decisions of import, even to the extent of refusing treatment that others would rather he went along with.

Of course, many people recognise that some patients are simply not capable of such decision-making. Perhaps they also feel that certain patients, if left to their own devices, will be inclined to make decisions which are so harmful to their interests that they cannot reasonably be said to further their autonomy. We may say that such patients should be relieved of their power to choose. The rules which deal with capacity attempt to reconcile our paternalistic wish to protect the vulnerable with our overarching concern for the promotion of individual self-determination. The significance of finding that a patient lacks capacity after all is huge; he is robbed of the valuable chance to assert his own will

[3] Subject to well-worn exceptions such as implied consent and the doctrine of necessity

in an intimate area of his life. His decisions may be contracted out to someone "safer". Many therefore, deplore the use of status-based tests, which assign an automatic presumption of incapacity on the basis of arbitrary categorisation. The so-called "functional approach" is favoured. This is one, which centres on the *individual* patient's ability to make his own decision according to his own values and beliefs[4] regardless of his membership of any social group.

Gillick *Competence : Almost Child-Proof*

Section 8 of the Family Law Reform Act 1969[5] marks the first status-based boundary in this area of law. Its effect is to limit the presumption of competence to all patients aged 16 and over. The courts have strictly adhered to this statutory age limit, almost to the point of absurdity. In many cases a patient a few months shy of his sixteenth birthday will find his competence aggressively challenged. Once he passes that crucial milestone however, the burden of proof is reversed and he is suddenly in a much stronger position to see his wishes carried out[6]. This approach misunderstands the true nature of capacity which is properly understood as an incremental concept. No magical transformation occurs on a child's sixteenth birthday. Rather, his capacity will gradually increase with the passage of time and with greater experience of life.

The seminal case of *Gillick*[7] dismissed outright the suggestion that no minor is ever competent to make his own medical decisions. Adolescents under the age of 16 are more properly understood as being burdened with a rebuttable presumption of incapacity.

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[4] I. Kennedy & A. Grubb, *Medical Law*, (2000) (London: Butterworths) at p 606
[5] The equivalent in Ireland is Section 23 (1) of the Non-Fatal Offences Against the Person Act 1997
[6] See *Re E (A Minor) (Wardship: Medical Treatment)* [1993] 1 FLR 386 and *Re M (medical treatment:consent)*[1999] 2 FLR 1097
[7] *Gillick v West Norfolk and Wisbech Area Health Authority* [1985] 3 AllER 402

If they cannot displace it, their medical decisions remain the preserve of their parents. *Gillick* provided that a child might prove capacity by meeting a functional test; by demonstrating "a significant understanding and intelligence to enable him or her to understand fully what is proposed"[8]. Paul says**:** "When I was a child, I spoke as a child, I understood as a child"**.** The law of England as expressed in *Gillick* seems to agree with him. When a child can show that he understands as an adult, he should be treated as one. In essence the case recognises that a child's decision-making ability will improve with increasing maturity and that milestones based on age are arbitrary and unreliable. We can flesh *Gillick* out with the formula for comprehension-based capacity familiar from the adult cases of *Re C*[9] and *Re MB*[10]. Wall J affirmed these cases as an appropriate guide to child capacity in the 1997 case of a young girl suffering from anorexia.[11]

The Functional Threshold

Under *Re C*, an adult patient is competent unless he is incapable of comprehending the nature, purpose and effects of the treatment at issue. There are three elements to this understanding: He must be able to understand and retain the relevant information, believe it (albeit "in his own way"[12]) and weigh it, balancing risks and needs so as to arrive at a true choice. Decision-making capacity under this test therefore, is just that; the ability to go through the pure mechanics of making a choice. *Re MB* hammers this point home, emphasising that in applying this test, perceived unreasonableness of outcome of a patient's decision might not be equated with incompetence. However

[8] *ibid* at 423 *per* Lord Scarman
[9] *Re C (Refusal of Medical Treatment)* [1994] 1 W.L.R. 290.
[10] *Re MB (Adult: Medical Treatment)* [1997] 8 Med. L.R. 217 at 224.
[11] *Re C (Detention:medical treatment)* [1997] FLR 180.
[12] *supra* n3 at 624

unorthodox, surprising or unwise a patient's choice may be, once it is the clear product of his unimpaired reasoning it will be allowed to stand. This remains the case "even though the consequence may be her own death".

It is important to note that the test prioritises the patient's ability to understand or his reasoning power rather than his *actual* understanding of a given situation. Certainly, failure to understand may be an indicator of that mental impairment that nullifies an expression of choice under *Re C*. However it may also indicate that the patient has simply not been provided with enough information to allow him to properly comprehend his situation[13].

Therefore, as the law in this area stands, only a so-called "defect of reason" such as a severe learning disability or certain kinds of psychiatric illness will rob an adult of the chance to make his own medical decisions.

…As Applied To Adolescents

The courts apply the same criteria to establish adolescent as adult understanding but do so in a manner, which is entirely at odds with the key features of the adult test[14] outlined above. There is a distinct judicial reluctance to define with any precision *what* it is that the competent adolescent must be able to understand in order to establish competence. The case law tells us that the courts set a high standard for adolescent decision-making. While "a decision …made by [an adult] … does not have to be sensible, rational or well-considered"[15], an adolescent making the same decision must demonstrate considerable understanding as well as intellectual rigour and wisdom approaching that of Solomon.

[13] *supra* n3 at pp 615-617
[14] J. Mansfield "United Kingdom - Refusal Of Treatment (Child): Competence" (1999) 7 Medical Law Review 58
[15] *ibid*

Lord Scarman in *Gillick* felt that a child must understand more than the nature, purpose and likely consequences of contraceptive treatment in order to consent to it. She must also comprehend "moral and family questions", issues of "emotional impact" and "risks to health"[16]. A child who is *Gillick*-competent to refuse treatment within the meaning of *Re R* [17] must demonstrate "a full understanding and appreciation of the consequences both of the treatment in terms of intended and possible side-effects and equally important, the anticipated consequences of a failure to treat."[18]

The outcome of an adolescent's decision, particularly where that outcome will be the child's death or serious impairment is crucial. As we have seen, this is not the case where adults are concerned. In *Re L*[19], a 14-year-old Jehovah's Witness, mature for her age and with sincere religious convictions was found to lack capacity to refuse a blood transfusion since she lacked "constructive formulation of an opinion, which occurs with adult experience". Stephen Brown P referred to the "sheltered life" that L had led and to her "limited experience of life". Surely these faults are readily generalised to all teenagers ? In *Re S* [20] the court ruled a 15 ½ year old incompetent because she did not understand the painful and distressing manner in which her death would occur and because she seemed to hoping for a miracle. How many adults have found it difficult to contemplate their own death in detail? How many have wished for a miracle? The decision in this case amounted to condemning her for her human nature.

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[16] *supra* n3 at 647
[17] *Re R (a minor)(wardship; consent to treatment)* [1992] FLR 11
[18] *ibid* at 26 *per* Lord Donaldson M.R.
[19] *Re L (medical treatment:Gillick competency)* [1998] 2 FLR 810
[20] *Re S (A Minor)* (Consent to Medical Treatment), 1995 FCR 605

Finally, in an approach described as a "device patently intended to justify a finding of incompetence"[21] adolescents are required to demonstrate actual understanding of their situation rather than the mere evidence of requisite reasoning power required of adults. *Re E*[22] concerned a Jehovah's Witness aged 15 ¾ who did not want a life-saving blood transfusion. Ward J held that the boy was not competent to withhold his consent because, although he was aware that death would follow upon his refusal, he did not understand the horrendous way in which his death would occur. This seems an unduly harsh approach considering that he had never been told, either by the judge or the doctors, exactly what his death would involve. In effect therefore, incapacity had been imposed upon him by withholding information from him[23]. In *Re L,* the girl's doctor had deliberately kept her in the dark as to the manner of her death. She was found incompetent where she was merely uninformed, and then blamelessly so.

On the face of it, the law recognises that adolescents are near-adults. The same test for capacity is applied to children as adults. However, the courts are clearly not satisfied to allow teenagers to embrace fully the challenges and responsibilities that come with increasing maturity. The manner in which these tests are applied amounts to *de facto* discrimination against teenage patients, clearing the path for proxy decision-making.

[21] *supra* n13 at 63
[22] *Re E (A Minor) (Wardship: Medical Treatment)* [1993] 1 FLR 386
[23] C. McCafferty "Won't Consent? Can't Consent! Refusal of Medical Treatment" 29 *Family Law Journal* 335

Gillick – *Parental Guidance ?*

Gillick established that absolute parental control had no place in decision-making for the "mature minor". It stopped short however, of determining that exclusive parental competence was to be replaced with absolute "adult level" competence on the child's part. Certainly, Lord Scarman[24] had said that "the parental right to determine whether or not their minor child below the age of 16 will have medical treatment *terminates*" [25] when that child acquires *Gillick* competence. However he further affirmed that: "parental rights clearly exist and do not wholly disappear until the age of majority". Eekelaar notes that Lord Fraser's judgment does not broach the subject of refusal and indeed seems to contemplate that in some situations, parental rights survive the minor's acquisition of capacity[26].

The judgments of Lord Donaldson MR in *Re R*[27] and *Re W*[28]clarify the peculiar nature of *Gillick* competence. In *Re R*, using a 'keyholder' analogy, he defined it as an adolescent power to consent to his own treatment, but one to be held concurrently with his parents' right of proxy consent and on an equal basis with them. So there are two "consent keys"; one held by the parents, one by the child and each capable of unlocking the door to treatment. The child's power of consent nullifies the parental power to *determine* what treatment the child will have: if they will not consent to it for him, he may do so on his own behalf; if they will not use their key he may use his[29]. Of course the argument works both ways; parents may use their key in the face of a child's refusal to do so. Thus, the parental power of *consent* survives *Gillick* unscathed: while the child

[24] *supra* n3 at 423-424
[25] My emphasis
[26] J. Eekelaar, "The Emergence of Children's Rights" (1986) 6 *OJLS* 161 at pp 180-181
[27] *supra* n17
[28] *Re W (a minor)(medical treatment)* [1992] 4 All ER 627

may of course refuse treatment he cannot do so *effectively*.. The subsequent case of *Re W* is notable for Lord Donaldson's rejection of the keyholder analogy and by extension the notion of an the right of refusal as part and parcel the right of consent. A key can lock as well as unlock but "no minor of whatever age has power by refusing consent to treatment to override a consent to treatment by someone who has parental responsibility for the minor"[30] Curiously, Lord Donaldson chose to describe *Gillick*-competence as a mere "flak jacket" for the medical profession, whose primary purpose is to guard medical personnel from lawsuits.

It is submitted that the inequality inherent in Lord Donaldson's sub-species of consent is grossly at variance with English law's autonomy-based approach to this area of law. *Gillick* capacity may be called a creature of law and not of logic[31] since surely a right of consent without a corresponding right to withhold it is devoid of meaning? [32]. For consent to really mean something "people must have the right to make choices that accord with their own values regardless of how unwise or foolish these choices may appear to others"[33]. Previous decisions such as that in *Sidaway*[34] emphasised that a right to *decide* is crucial to the concept of consent. It should be recalled that English law has rejected the jurisprudence of the "nanny court" in other areas and perhaps in time, we will see such change here[35].

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[29] See *Re P (a minor)* [1986] 1 FLR 272 : A *Gillick* competent schoolgirl aged 15 could have an abortion against the wishes of her parents.
[30] *supra* n28 at 639
[31] J. K. Mason and R. A. McCall Smith, Law and Medical Ethics (Butterworths, 5th edn, 1999), at p 260.
[32] R. Huxtable "Time to remove the 'flak jacket'?" 12 *Child and Family Law Quarterly* 83
[33] Robins JA in *Malette v Shulman* (1990) 67 DLR (4th) 321 (Ont CA)
[34] *Sidaway v Governors of Bethlehem Royal Hospital* [1985] 1 All ER 821 at 865-866 per Lord Goff.
[35] In the Caesarean section context: the law as laid down in *Re S* (Adult: Refusal of Treatment) [1993] Fam 123 and other authorities effectively denied pregnant women the power to refuse treatment. This approach was powerfully rejected in *St George's Healthcare NHS Trust v S*, *R v Collins ex parte S* [1998] 3 All ER 673.

For the present the child-specific half-capacity proffered in *R* and *W* holds sway. In *Re M*[36], for example, where the court authorised a heart transplant against the wishes of a 15½-year-old woman the judge, Johnson J, remarked that her parents could have done so. In *Re K, W and H*[37] compulsory psychiatric treatment was ruled legal on the basis of parental consent alone. The upshot for the "mature minor" is that the efficacy of any competent refusal by him is subject to his parents' willingness to respect it.

Best Interests – Better Safe Than Sorry

Thus far we have concerned ourselves with the allocation of decision-making rights as between "mature minors" and their parents. It appears however that the courts also enjoy a slice of the decision-making cake. They have, in the exercise of their inherent jurisdiction reserved for themselves the power to overrule "dangerous" choices made by or on behalf of the young.

Even if parents accepted their mature minor's withholding of consent, that refusal might not bind. *Re R* and *Re W* confirmed that the courts are willing to nullify an adolescent decision in the exercise of their *parens patriae* jurisdiction. In *Re W*, Balcombe LJ limited the court's power to cases of a refusal, which would "in all likelihood lead to the death of the child or to severe permanent injury". Lord Donaldson MR appeared to contemplate a much broader power of veto, stating that the inherent powers of the court under its *parens patriae* jurisdiction are not merely equivalent to parental powers but are rather "theoretically limitless"[38]. Surely then the courts' power

[36] *Re M (medical treatment:consent)*[1999] 2 FLR 1097
[37] *Re K, W and H (Minors) (Medical Treatment)* [1993] 1 FLR 854
[38] *supra* n3 at 987

extends to overruling a competent minor's *consent* to treatment? Grubb notes that Staughton LJ in *Re W* explicitly contemplates that it can[39].

A parent's power to choose for his child is not inviolable. Just as the court's inherent jurisdiction stretches to "protecting" children from their own "irrational" choices so it shields them from unreasonable decisions made on their behalf. *Gillick* endorsed a trustee approach to parental proxy decision-making: "parental rights to control a child … exist for the benefit of the child".

In the end the acid test of any treatment decision made by or for a child is the "best interests"[40] test. Any decision in which the welfare of the child has not been the paramount consideration will fall. Grubb[41] maintains that the court's role in applying this test has two strands. The court as legislator sets out the criteria of best interests which mark out the four corners of legitimate discretion on the part of the initial decision-maker, be that parent or child. Thereafter as supervisor it must determine whether those criteria have been applied and that they haven't been applied in a manifestly absurd fashion. The court will weigh the various interests at play[42] and if the original decision is reasonable in light of that final balance it will stand[43]. The court must weigh into the balance the "ascertainable wishes and feelings of the child concerned, (considered in the light of his age and understanding)"[44]. Parental wishes are similarly factored into the equation but neither is determinative[45]. The arbitrary and astonishingly flexible manner in

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[39] *supra* n3 at 988
[40] See *Re J (A Minor)* (Wardship: Medical Treatment) [1991] 1 FLR 366 at 381.
[41] *supra* n3 at 801
[42] See *Re A (medical treatment:male sterilisation)*[2001] 1 FCR 193 (CA)
[43] *Re T (Wardship: Medical Treatment)* [1997] 1 FLR 502
[44] *supra* n3 p 817
[45] See *Re P (a minor)* (1981) 80 LGR 301 and *Re B (Wardship:Abortion)* [1991] 2 FLR 42 where parental objections to abortion were outweighed by concerns for the childrens' health

which this test is applied may cause us to question whether anything at all is gained by taking these decisions out of the hands of children.

It has been argued that treatment will only be in the best interests of a patient if it is medically therapeutic. In *Re F*[46] Lord Goff spoke of therapeutic action as that which aims "to preserve the life, health or well-being" of the incompetent patient himself. That rule has since softened in the light of other considerations. The courts have accepted, as in *Re MB*, that "[b]est interests are not limited to best medical interests" but can encompass social, emotional and psychological benefits. This modified concept of best interests has been employed to justify the authorisation of treatment, which might be viewed by some as purely cosmetic, such as the separation of conjoined twins. In a case involving such twins: *Re A*[47], Robert Walker LJ felt that Mary's momentary recapturing of "the bodily integrity and dignity which is the natural order for all of us" meant the separation was in her best interests, even though it would inevitably result in death..

The rule that "best interests" means "best interests of the patient himself" has been modified on a similar basis. In *Re Y*[48] it was stated that parents cannot consent to a procedure which is in the interests of a sibling while *Re Eve*[49] established that they could not do so in own interests for their own convenience. English law imposes no duty of rescue or altruism, even to siblings. However this issue too has been circumvented by converting the interests of others into the currency of the best interests of the patient. This reasoning has been used to great effect in a series of "sibling donation" cases. In *Strunk v*

[46] *Re F (mental patient:sterilisation)*[1990] 2 AC 1 at 76
[47] *Re A (Children)(Conjoined twins)*[2000] 4 All ER 961
[48] *Re Y* (Mental Incapacity:Bone Marrow Transplant) [1996] 2 FLR 787
[49] *Re Eve* (1986) 31 DLR (4th) 1 (Can SC)

Strunk[50] the court authorised an incompetent man's donation of his kidney to his ill brother, reasoning that he would gain benefit from continued contact with his brother to whom he was very close. The courts have also recognised an almost symbiotic relationship between parents and their dependant children. In *Re T* [51]a mother's refusal of a lifesaving liver transplant for her son was upheld on grounds of her professed reluctance to care for him in the event of a forced operation. It was essentially held to be in the ill child's interests that his mother not be compelled to carry out burdensome care.

"Best interests" criteria are of necessity subjective and indeterminate. Their application has lead to outcomes as polarised as that in *Re T* and *Re B*[52] where the parents' refusal of an operation to correct their disabled baby's intestinal blockage was overruled. The best interests test does nothing for legal certainty. Its only possible justification is as a safety catch: ensuring that where controversial decisions cannot be avoided they at least receive the rubber stamp of trustworthy court supervision.

The Medical Imperative: A Safe Pair of Hands ?

The final question concerns how far the court may go in ensuring that the desired course of treatment is followed. It is clear that the wilful refusal of treatment by an adolescent is no object. The court has the power to consent on his behalf and to authorise restraint and the use of reasonable force under its inherent jurisdiction[53]. Grubb[54] however, notes that the court has power to authorise treatment but not to *order* that it be carried out. That

[50] *Strunk v Strunk* (1969) 445 SW 2d 145 (Ky CA)
[51] *Re T (a minor)(wardship:medical treatment)* (1996) 35 BMLR 63 (CA)
[52] *Re B (a minor)(wardship:medical treatment)* [1981] 1 WLR 1421 (CA)
[53] See *Re W supra* n28.
[54] *supra* n3 at 819

privilege belongs to the medical profession .*Re J*[55] established that the courts will not endorse a right to treatment where it is against a doctor's clinical judgment to provide it. Furthermore decisions of public authorities such as primary care trusts are not subject to the "best interests" calculus. *R v Cambridgeshire Health Authority*[56] established that the court was not entitled to investigate the merits of the Health Authority's decision but only its legality. It is not concerned with resource allocation or financial decisions *unless* the decision to allocate in the way it was could be characterised as "irrational": made in a manner which is other than fair, consistent and coherent [57]. All the law asks of the medical man's decision is demonstrable logic. Perceived unreasonableness, though a red flag for intervention in adolescent and parental decision-making, has no application in the context of resource allocation.

Medical Decisions- Keep Out Of Reach Of Children

In conclusion, the path from initial decision to medical conclusion is a difficult one. Adolescents do not approach the issue of capacity on the level. The law distrusts their judgment and so places them on the bottom tier of a hierarchy of increasingly paternalistic arbiters. It is unlikely that their own wishes will play any greater role in the resolution of their dispute than that of a factor in the vague and indeterminate best interests balance. I have argued that there are no clear benefits attached to the application of the best interests test short of its ability to confer a certain peace of mind on third parties. Is this enough to justify interference with the intimacies of the individual

[55] *Re J (a minor)(child in care:medical treatment)* [1993] Fam 15
[56] *R v Cambridgeshire Health Authority; ex parte B (a minor)* (1995) 23 BMLR 1 (CA)
[57] *supra* n3 at 9

decision-making process? It may be useful to conclude by noting that however adolescents and adults are treated in determining issues of capacity, in the end they are equally helpless against the law's unwavering faith in the inherent soundness of a medical man's decision. However we in Ireland might choose to fashion our law on adolescent capacity when our turn comes, *that* is a factor which is as likely to affect our children as their English counterparts.